Recent Research Findings on Medicare+ Choice

Policymakers are debating how best to structure Medicare+Choice for the future and need to be up-to-date on current research about how the program operates, from how plans decide to participate or withdraw to how much Medicare beneficiaries actually know about the services and the service quality of the options they choose. This Operational Insights highlights key findings from recent journal articles and reports that collectively contribute to a better understanding of the Medicare+Choice program in five areas: why plans withdraw and the effect on beneficiaries, supplemental coverage trends, beneficiary education, plan selection and risk adjustment, and the effects of managed care on quality and health satisfaction.

**Plan Withdrawals**

Medicare managed care enrollment grew rapidly before the passage of the Balanced Budget Act (BBA) of 1997, but slowed considerably after it went into effect and has been declining since 2000. At the same time, there has been a sharp reduction in the number of participating plans (Gold, 2001a). Reasons for plans’ participation decisions include payment, level of competition, and ability to form provider networks. Some plans withdrew from areas where they could not compete effectively or establish sufficient provider networks (GAO, 1999). Recent research shows that, in addition to payment, market factors such as historic managed care and practice patterns, beneficiaries’ care expectations, other lines of business, state regulation, and geographic proximity to other markets influence the state of Medicare managed care locally (Brown and Gold, 1999; Dallek and Jones, 2000; Pai and Clement, 1999).

It is widely believed that most plans withdrew because payment increases in many urban market areas were minimal—only 2 percent. Withdrawals were not limited to counties with low payments, however, and larger payment increases in rural areas have not stemmed withdrawals from the program. In 2000, 7 percent of counties with at least one Medicare+Choice plan in operation the year before received a payment increase of 10 percent or more. Despite these increases, nearly 40 percent of these counties experienced plan withdrawals (GAO, 2000).

Additional benefits at low cost are a major reason why enrollees join Medicare+Choice. The pressure to maintain benefit levels developed when payments were rising more rapidly than they are now and probably contributes to plan perceptions that payments are inadequate. Plans that terminated their contracts in 2000 or 2001 reportedly spent 22 percent of their Medicare payments (about $1,200 per beneficiary) on additional benefits (GAO, 2000). According to the General Accounting Office (GAO), the size of the rate increase needed to make participating plans attractive may conflict with the pressures to make the program financially stable in the long term.

The share of Medicare beneficiaries affected by withdrawals has increased dramatically in the last two years. Withdrawals in 2001 affected about one million persons, or 15 percent of enrollees, compared to 328,000 persons, or 5 percent of enrollees, in 2000. By 2001, nearly 75 percent of the counties that had a Medicare+Choice plan in 1999 experienced some change in plan participation. The number of beneficiaries who will have no other Medicare managed care choice, and must either switch to a non-managed care...
option or return to a fee-for-service or indemnity plan, doubled from 79,000 in 2000 to 159,000 in 2001 (GAO, 2000).

The effects of withdrawals on beneficiaries are worsening over time. In 1999, 15 percent of beneficiaries enrolled in a terminating plan had no supplemental coverage (GAO, 1999), and a year later one study showed that 27 percent did not have coverage beyond basic Medicare. Moreover, research shows that these individuals were disproportionately least educated and had low incomes (Gold and Justh, 2000).

In addition, beneficiaries in terminating plans were more likely to experience an increase in their premiums and/or some disruption of their medical care arrangements. Beneficiaries who enrolled in another Medicare health maintenance organization (HMO) were less likely to lose benefits and incur higher premiums, but they were more likely to face disruptions in their care arrangements (Barents LLC and WESTAT, 1999). Those who returned to traditional Medicare were more likely to lose their supplemental benefits, report concerns about costs, and experience disruptions in care (Barents LLC and WESTAT, 1999; Gold and Justh, 2000).

While all beneficiaries were affected by withdrawals, those in rural areas were hurt disproportionately (GAO, 2000). Even at the peak of Medicare+Choice enrollment, rural beneficiaries had fewer choices and less generous benefit packages than most urban beneficiaries. This is most likely due to the difficulty and high cost of forming provider networks and marketing to a widely dispersed beneficiary population (MedPAC, 2001).

In 2000 and 2001, Medicare+Choice plans have tended to withdraw from more difficult-to-serve rural or urban areas where they had low enrollment. Through Medigap find it increasingly expensive. Drug coverage trends for 1997-1998 show small decreases in coverage rates in almost all categories. Beneficiaries in Medicare HMOs experienced the sharpest decline, with 96 percent having drug coverage in 1997 and only 92 percent in 1998, and the proportion of all supplemental policyholders with such coverage dropping from 44 percent to 43 percent (Poisal and Murray, 2001). There is also a wide gap in the source of prescription drug coverage: 92 percent of Medicare HMO beneficiaries and 89 percent of beneficiaries with employer-sponsored coverage had drug coverage in 1998, compared with 43 percent of beneficiaries with individually purchased Medigap (Poisal et al., 1999).

Medigap coverage is not only less prevalent, it is also increasingly expensive. Between 1998 and 2000, the average rate increase implemented by 144 Medigap insurers was 20.2 percent (Weiss Ratings, 2001a). In 2000, the average annual standard premium for a man age 65 was $1,239 for Plan C, up 16.4 percent from 1998, and $1,301 for Plan F, up 11.8 percent from 1998 (Weiss Ratings, 2001b).

High prices contributed to the low purchase rate for Medigap policies with drug coverage among new beneficiaries in the last 10 years (Chollet, 2001). Premiums for Medigap plans with drug benefits (H, I, and J) rose an average of 37.2 percent from 1998 to 2000—more than twice the rate of plans without drug coverage. This premium increase appeared to be driven by adverse selection (Atherly, 2001; Weiss Ratings, 2001b).

There are additional barriers to Medigap drug coverage. To begin with, all insurers in all markets do not offer Medigap plans. In addition, if beneficiaries do not enroll in a Medigap policy during the first six months when they become eligible for Medicare, they may be subject to health screens (questions about their health) when they apply later, or

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they may be turned down for coverage (Gold and Mittler, 2001). Overall, beneficiaries without prescription drug coverage used fewer prescription drugs and continued to pay much more out-of-pocket for their drugs, even though they used fewer medications than their covered counterparts (Poisal and Murray, 2001).

The cost of supplemental insurance can have a significant impact on who gets covered:

• The high cost of supplementary coverage places poor and near-poor beneficiaries at the greatest risk for higher out-of-pocket health costs. Nearly 60 percent of beneficiaries with incomes below the poverty level did not receive Medicaid assistance in 1997. These beneficiaries spent, on average, about half their income out-of-pocket on health care, regardless of the type of plan in which they were enrolled. Even though HMOs can offer lower-cost health care, beneficiaries in Medicare HMOs tend to have lower incomes than other beneficiaries, so the Part B and HMO premiums they have to pay are still a substantial financial burden (Gross et al., 1999).

• Researchers found consistent socio-economic differences among beneficiaries covered by different kinds of supplemental policies. Those with employer-sponsored coverage typically were healthier, better educated, and have higher incomes than other beneficiaries. Race/ethnicity is an important predictor of supplemental coverage status. Only 9 percent of whites had no supplemental coverage in 1996 versus 15 percent of Hispanics and Asian Americans, and 27 percent of African Americans. Similarly, whites were more likely to have employer-based or Medigap coverage. Hispanics and Asian Americans were most likely to have Medicaid, and whites were least likely to have Medicaid coverage (Pourat et al., 2000).

• While beneficiaries with supplemental coverage are less likely than those without it to incur catastrophic expenses, their coverage increases overall Medicare expenditures because beneficiaries with supplemental coverage tend to spend more. The size and impact of these increases vary by study because of variations in data, study and empirical methodology, and legislative changes (Atherly, 2001). According to one study, having either Medigap or employer-sponsored coverage increased Medicare spending by about 42 percent more than spending by those without supplemental coverage, and those with both Medigap and an employer-sponsored plan incurred 62 percent more in costs. Having both types of private policies may serve as an incentive to use more services (Khandker and McCormack, 1999).

Beneficiary Education

An important component of the BBA is to ensure that beneficiaries have adequate information to make decisions about Medicare+ Choice. The law requires the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) to implement initiatives to help beneficiaries understand the available choices through printed materials, the Internet, and a toll-free telephone number (MedPAC, 1999). This effort—the National Medicare Education Program (NMEP)—was launched as a pilot effort in five states in 1998 and then was extended nationally in 1999 (see box: Successes in Medicare Education).

Despite national and local-level efforts to educate Medicare beneficiaries about their choices, most still do not understand the basics of the Medicare program and Medicare+ Choice (Barents LLC, 1998; Hibbard et al., 1998; Murray and Shatto, 1998; Stevens and Mittler, 2000). Several factors complicate the task of educating Medicare beneficiaries.

• Most beneficiaries seek information only when they have a problem (Barents LLC, 1998; Stevens and Mittler, 2000), and then they go to the Medicare program or other government sources for basic program information. State Health Insurance Information Assistance Programs (SHIPs) also provide unbiased information, as well as individual insurance counseling, but many beneficiaries do not know about their local SHIPs.

• Beneficiaries often rely on their providers, family and friends, and health plans for information about the Medicare program (Barents LLC, 1998; Gold et al., 2001, and Stevens and Mittler, 2000). However, those providing informal sources of information, such as adult children, often are not knowledgeable enough about Medicare to help their parents with health and financial decisions (The Family Circle/Kaiser Family Foundation, 2000).

• Lack of knowledge about the Medicare program leads to underenrollment among some groups. In Los Angeles, only 71 percent of the eligible Hispanic immigrant population was enrolled in Medicare, compared with 95 percent of non-Hispanic whites and 89 percent of U.S.-born Hispanics. Belief that Medicare is a welfare program and that citizenship is required to enroll also impedes enrollment (Hayes Bautista et al., 2001).

New research on beneficiary decision making shows that literacy and comprehension were key problems among beneficiaries. Approximately one-third of English-speaking and more than half of Spanish-speaking beneficiaries could be classified as having inadequate or marginal health literacy— for
example, inability to read simple materials such as prescription drug instructions and appointment slips (Gazmararian et al., 1999). Approximately 56 percent of the Medicare population was estimated to have poor comprehension skills for comparative information, with Medicare beneficiaries making almost three times as many errors as younger respondents (Hibbard et al., 2001).

Beneficiaries in poorer health, with less education, and who were older tended to make more errors than those who were in better health, had more education and were younger (Hibbard et al., 2001). Both health literacy and comprehension declined after age 80 (Gazmararian et al., 1999; Hibbard et al., 2001). Beneficiaries with poorer comprehension skills were more likely to want to delegate their decision making to a proxy—for example, an adult child—and to view additional information and options as unwelcome. However, they were no more likely to have sought help than were those with greater skills (Hibbard et al., 2001).

For beneficiaries who need to make a choice, finding unbiased information is neither easy nor consistent under constantly changing Medicare+Choice market conditions. Medicare education at the local level is not widespread, and when it does take place, it is often dispersed across different public and private organizations that lack the resources to reach the most vulnerable beneficiaries.

Beneficiaries’ decision making is complicated by changes in the availability of managed care plans at the local level and in the benefits being offered. Changes at the provider level, such as when subgroups of providers or systems no longer participate in a specific plan, complicate choice further because beneficiaries cannot simply make a choice and put it behind them; rather, they may need to revisit their choices even after their plan has stayed in the market for the year (Stevens and Mittler, 2000).

Plan Selection and Risk Adjustment
One way to ensure that Medicare+Choice plans are paid fairly for the populations they enroll is by risk adjusting payments to them. By putting plans on a level playing field, they can compete on the basis of benefits and services, not on the attraction of low-cost versus high-cost enrollees (MedPAC, 2000). Recent research shows that plan selection by beneficiaries remains a problem: HMOs still attract healthier beneficiaries and experience favorable disenrollment (Aber and McCormick, 2000; Hellinger and Wong, 2000; Call et al., 1999). HMO disenrollees spent more for and received more surgical care and were hospitalized for more ambulatory care-sensitive conditions upon disenrollment than fee-for-service beneficiaries. This trend increased as market share increased (Call et al., 2001). While HMO disenrollees were significantly more likely to have exhausted their outpatient drug benefits, and tended to be sicker and have a higher number of prescriptions, physician visits, and hospital admissions than those who were still enrolled, the study did not determine whether, upon disenrollment, beneficiaries switched to fee-for-service, where they would not get additional drug benefits, or to another HMO that offered a drug benefit (Rector, 2000).

Counter to some hypotheses, for-profit HMOs did not experience favorable selection any more than their nonprofit counterparts; in fact, over the last decade, an increasing number of substantially poorer and less educated older Americans are enrolling in for-profit HMOs than in nonprofit HMOs in hopes of reducing their out-of-pocket costs (Blustein and Hoy, 2000).

In January 2000, CMS implemented principal inpatient diagnostic cost groups (PIPD CGs), a form of risk adjustment based on hospital inpatient diagnoses. Using this

### Successes in Medicare Education

CMS’s Medicare & You handbook has had some influence on beneficiaries’ decision making, and studies show that beneficiaries who have read it are significantly more likely to be knowledgeable about the Medicare program, be aware of different plan options, and have thought about or decided to switch health plans than those not exposed to the handbook (McCormack et al., 2001).

Specially designed consumer choice handbooks with worksheets that break the insurance decision-making process down into small steps seem to help beneficiaries understand cost/benefit comparisons and identify options based on one factor at a time, such as costs or coverage (Harris-Kojetin et al., 2001). Knowledge can translate directly into helping beneficiaries get better health care. For example, those who knew about benefits for flu shots and mammograms are 33 percent more likely to have had the shot and 16 percent more likely to have had a mammogram than those who did not know these benefits were available (Barets LLC, 1998). Research shows that comprehension drives salience—that is, if beneficiaries do not understand certain types of comparative plan information, they are more likely to ignore them or consider them unimportant (Lubalin and Harris-Kojetin, 1999).
model, studies show that healthier beneficiaries select Medicare HMOs. In particular, a comparison of the average risk factors between these two groups shows that managed care populations tend to be less costly (Greenwald et al., 2000).

While evolving methods of adjusting for risk in the Medicare program have promise in reducing overpayments to HMOs that enroll healthier beneficiary populations, research shows that further modeling is needed. For example, risk-adjustment models that use diagnoses from multiple sites (physician visits and hospital inpatient and outpatient encounters) remove disincentives associated with substituting ambulatory care for inpatient care (MedPAC, 2000). Other risk-adjustment models that distinguish between the aged and disabled would also be useful and are a focus of current research (Ash et al., 2000; Greenwald, 2000; Riley, 2000). A factor complicating the implementation of existing and new risk-adjustment models is that plans have concerns about the related data collection and administrative demands.

Health Satisfaction and Quality
The BBA mandates that health plans collect data, such as CAHPS and the Health Plan Employer Data and Information Set (HEDIS), to permit ongoing program evaluation and, in some instances, provide performance measures for beneficiaries to understand their options. To date, few quality studies related to the Medicare+Choice program have been published, with the exception of consumer satisfaction studies.

Research examining plans’ and consumers’ use of CAHPS data has found that plans with high CAHPS scores invested heavily in customer service and consumer education, recruited providers known to communicate well, and linked providers’ incentives to patients’ reported experiences through financial incentives and performance feedback (Gerteis et al., 2000). However, competitive pressures, lack of timeliness, and lack of access to the raw data limited plans’ ability to use CAHPS results for quality improvement (Smith et al., 2001). Reporting CAHPS data about the delivery of care at the doctor’s office, a plan’s customer service, access to medical services provided by the plan (such as therapy or equipment), and advice on health-promoting activities could potentially simplify reporting about performance information to consumers, since these factors accounted for most of the variation in scores among health plans (Zaslavsky et al., 2000).

Comparisons of the quality of care between HMOs and non-HMOs have been mixed—sometimes HMOs rate better, sometimes they are worse (Miller and Luft, 1997). A recent review of the literature on use of preventive services by all managed care enrollees shows that provision of preventive services was neither better nor worse in managed versus non-managed plans, and there were no differences in the use of preventive services between Medicare managed care enrollees and other enrollees. However, it is possible that there are differences among subgroups within Medicare, but that sample sizes were too small to detect them (Phillips et al., 2000).

Researchers also have found that Medicare managed care has not reduced the number of discretionary hospitalizations for beneficiaries any more than fee-for-service (Porrell and Gruenberg, 2000), and that Medicare managed care beneficiaries have no more problems accessing certain therapies than their fee-for-service counterparts. Based on two studies of breast cancer and colorectal diagnosis and treatment, enrollment in an HMO actually may be beneficial in early diagnosis and lowering mortality (Merrill et al., 1999; Riley et al., 1999).

• Medicare HMO beneficiaries had breast cancer diagnosed at earlier stages than women in the fee-for-service setting, possibly due to increased education and availability of screening by HMOs and lower out-of-pocket costs (Riley et al., 1999).

• Medicare HMO colorectal cancer patients had a lower overall mortality than their fee-for-service counterparts and a similar use of certain surgical procedures (Merrill et al., 1999).

The main caveats to these studies are that the data are from the late 1980s and early 1990s and do not reflect recent changes in the managed care market, and favorable selection into HMOs may bias the outcomes.

Opportunities for Future Research
There are several areas for future research about Medicare+Choice, especially given the Bush administration’s and Congress’s interest in expanding the program. These include:

• improving the relevance and dissemination of quality and choice information to beneficiaries;

• finding ways to improve care in rural areas without private managed care plans; and

• identifying ways to provide prescription drug coverage to all beneficiaries (Gold, 2001b).

About the Data
The data are from literature reported in the Medicare+Choice Monthly Tracking Report as part of the Mathematica Policy Research, Inc. (MPR), Monitoring Medicare+Choice Project. The period covered in the reports is February 1999—July 2001.
References


